

# Medicaid ACH-PCS Cost Settlement

Adult Care Home with Special Care Unit Beds

2006 - 2007

REPORT DUE DATE: JANUARY 31, 2008

Facility Name:	_____	Facility Address:	_____
County:	_____	City, State, Zip Code:	_____
License Number:	_____	Medicaid Provider Number:	_____
NPI Number:	_____		
FID Number:	_____	Cost Reporting Period: From	Through

Line #	ITEM	AMOUNTS
1.	Total: Personal Care Service Cost	1. _____
2.	Total: Health Services	2. _____
3.	Total: Initial/Orientation Aide Training	3. _____
4.	<b>Add:</b> [Line #1 plus Line #2 plus Line #3]	_____
5.	Total: Facility Costs minus Administration Cost	5. _____
6.	Total Administration Cost	6. _____
7.	Administration Cost Factor [Divide Line #6 by Line #5]	_____
8.	Loaded PCS Costs [Multiply Line #4 by (Line #7 + 1.00)]	_____
9.	Resident Days	9. _____
10.	SA (Medicaid) Days	10. _____
11.	Medicaid % [Divide Line #10 by Line #9]	_____
12.	Medicaid Loaded PCS Cost [Multiply Line #8 by Line #11]	_____
13.	Medicaid PCS Payment	13. _____
14.	Balance Now Due: [Line #13 minus Line #12 but do not enter less than \$ 0.00]	_____

## Line # Cost Report Schedule References

1. Schedule C, Line 60, Column 7
2. Schedule C, Line 80, Column 7
3. Schedule C, Line 90, Column 7
5. Schedule C, Line 240, Column 7 minus Schedule C, Line 120, Column 7
6. Schedule C, Line 120, Column 7
9. Schedule A, Line 19
10. Schedule A, Line 20
13. Schedule B, Line 4, Column 5

Signature of person filling out the form: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_

## MAIL FORM AND BALANCE DUE PAYABLE TO:

Division of Medical Assistance  
Finance Management-Rate Setting  
2501 Mail Service Center  
Attention: Elizabeth Grady  
Raleigh, NC 27699-2501